Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Jacqueline Evans, DC

Respondent Name
City of Corpus Christi – Risk Management

MFDR Tracking Number
M4-15-0469-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
October 2, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 133.250 (c) (2), consider this a formal 'request for reconsideration' because the provider has not received an EOB within 50 days from submitting the bill. Rule 133.250 (d) (2) states a request for reconsideration shall include an EOB only 'if received'.

Per Rule 133.240, the insurance carrier is required to take final action and send an EOB to the provider not later than the 45th day after receipt of the bill.

If a review has already been performed, please consider this a request for a copy of the EOB."

Amount in Dispute: $1150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 9, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 24, 2014	Designated Doctor Examination	$1150.00	$1150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.10 sets out the procedures for filing a CMS 1500 for medical services.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill by a health care provider.
4. 28 Texas Administrative Code §133.210 defines the requirements for medical documentation submission with medical billing.
5. 28 Texas Administrative Code §133.240 sets out the procedures for processing medical bills received by an insurance carrier.
6. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursing designated doctor examinations.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   No explanation of benefits was received with this dispute.

Issues

1. Did the requestor submit a complete medical bill according to 28 Texas Administrative Code §133.10, §133.20, and §133.210?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.10, "All information submitted on required paper billing forms must be legible and completed in accordance with this section." Review of the submitted documentation finds that the requestor submitted a properly completed, legible CMS-1500 according to 28 Texas Administrative Code §133.10.

   28 Texas Administrative Code §133.20 (b) states, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." A review of the submitted documentation finds convincing evidence that the requestor submitted a medical bill for date of service 2/24/14 on 3/10/14 and resubmitted the same on 5/22/14.

   Per 28 Texas Administrative Code §133.210 (b), "When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents." A review of the submitted documentation finds that the requestor included the required forms and narrative report with the billing for a designated doctor examination.

   Therefore, the Division finds that the requestor submitted a complete medical bill according to 28 Texas Administrative Code §133.10, §133.20, and §133.210.
2. 28 Texas Administrative Code §133.210 (e) states, "It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other." Therefore, the Division finds that requestor's submission of the complete bill to the adjuster satisfies the requirement to submit a complete bill to the insurance carrier. Further, submitted documentation fails to provide evidence sufficient to deny payment for the disputed services.

   28 Texas Administrative Code §134.204 (j) states, "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (3)(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." Submitted documentation supports that the requestor performed an examination to determine Maximum Medical Improvement. **Therefore, recommended reimbursement for this examination is $350.00.**

   28 Texas Administrative Code §134.204 (j)(4)(C)(ii) states, "The MAR for musculoskeletal body areas shall be as follows (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." Submitted documentation supports that the requestor performed a full physical evaluation with range of motion for the upper extremity – right shoulder. **Therefore, recommended reimbursement for this examination is $300.00.**

   28 Texas Administrative Code §134.204 (k) states, "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports." Submitted documentation supports that the requestor performed an examination to determine the injured employee's ability to return to work as requested. **Therefore, recommended reimbursement for this examination is $500.00.**

   The requestor is entitled to a total reimbursement of $1150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 14, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.